

WILD QUARTZ WELLNESS

massage therapy & holistic healing

NEW CLIENT INTAKE

Name _____ D.O.B. _____ Today's Date _____
Address _____ City _____ State _____ Zip _____
Cell phone _____ Work phone _____
Email _____ Occupation _____
Employer _____ Referred by _____
Emergency contact name _____ Relationship _____
Emergency contact phone _____

Insurance Information

Full Name _____ D.O.B. _____
Insurance Provider _____ Insurance group # _____
Billing address _____
City _____ State _____ Zip _____ Phone _____
Client's relation to insured (*circle*) Self | Spouse/Partner | Child

What Brings You In?

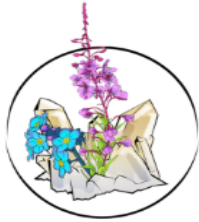
Circle all that apply: Mental Relaxation | Tight Muscles | Injury Recovery | Wellness | Other

Please list any areas of concern _____

Date of injury (*If applicable*) _____

Health History

Current Medications/Supplements and what are they taken for:



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List All Major Injuries, Illnesses, Surgeries and Dates

List any Accidents and Dates of Occurrence: (Were you injured? Did you see a doctor?)

Do you have sensitive skin? _____ Do you have any allergies to oils, lotions or ointments? _____

List any known allergies _____

Circle Any of the Following Conditions that Apply

Musculoskeletal

Bone or Joint Disease | Tendonitis | Bursitis | Arthritis | Gout | Jaw Pain (TMJ) | Lupus | Spinal Problems
Migraines | Headaches | Osteoporosis

Circulatory

Heart Condition | Phlebitis | Varicose Veins | Blood Clots | High Blood Pressure | Low Blood Pressure
Lymphedema | Thrombosis/Embolism

Respiratory

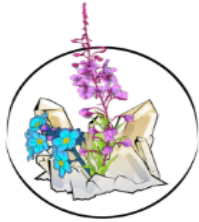
Breathing Difficulty | Asthma | Emphysema | Sinus Problems

Nervous System

Shingles | Numbness | Tingling | Pinched Nerve | Chronic Pain | Paralysis
Multiple Sclerosis | Parkinson's Disease

Reproductive

Pregnant, due date _____ Ovarian | Menstrual Problems | Prostate



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Skin

Rashes | Cosmetic Surgery | Athlete's Foot | Herpes | Cold Sores | Open Sores

Digestive

Irritable Bowel Syndrome | Bladder Infection | Kidney Problems | Colitis | Crohn's Disease | Ulcers

Psychological

Anxiety | Stress Syndrome | Depression | Mood Swings | OCD | Cold Sweats

Other

Diabetes | Cancer/Tumors - If yes, Location _____

Contact Lenses | Dentures | Hearing Aids

Any other medical condition(s) not listed: _____

Disclaimer: If you've listed certain medical conditions or specific symptoms, massage may be contraindicated. In some cases, massage may be able to be resumed with a doctor's note of approval. If using insurance, a referral from your primary care provider may be required prior to service.

Previous Experience

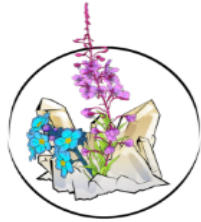
Have you received a professional massage before? _____

If yes, how frequently? _____

If yes, when was your last massage? _____

Do you have any goals in mind with your massage session?

What is your favorite part of a massage?



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What kind of pressure do you prefer? (*circle*) Light | Moderate | Firm

Client Agreement

I understand that the massage I receive is provided for relaxation and pain management. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure can be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination or diagnosis and that I should see a qualified medical specialist. Massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment. It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage.

Print name _____ D.O.B. _____

Signature _____ Date _____